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Evaluation of the Partnership for  
Transparency Project implemented by the  
Anti-Corruption Coalition in selected  
Health Centers in Lira district in Uganda



## **Executive Summary**

ACCU received support from the Partnership for Transparency Fund (PTF) to implement a 12 months project aimed at reducing leakage of malaria medicines by monitoring of the supply of medicines from the National Medical Stores (NMS) to target health centers. The project was implemented collaboratively with beneficiary communities, IBMs of Northern Uganda Anti Corruption Coalition (NUACC) and other health sector stakeholders in monitoring service provision at health centers. Project activities included undertaking a baseline survey, training Independent Budget Monitors (IBMs), undertaking Public Accountability Forums, establishment of a Health sector Anti-Corruption Working group and development of Information, Education and Communication materials for public awareness

Training IBMs enabled them to acquire knowledge and skills to effectively monitor drug supply from the district to Health Centers. IBMs undertook routine monitoring of Health Centers where they got information on drugs delivery, discussed patient-care issues with Health Centre staff, and talked to patients to establish their experiences in accessing services at the Health Centers. The IBMs also participated in radio talk shows to raise awareness about the project and mobilize communities to participate in reducing drugs leakages. PAFs were also held to discuss findings from monitoring.

Project implementation led to increased community awareness about drugs leakages and empowered them to detect government drugs on sale in private markets. IBMs are also currently recognized as the champions in the fight against drugs leakages. Through radio programs and the PAFs, community members were empowered about their rights to access medicines and quality service delivery. Communities were empowered to monitor leakage of government drugs. The project has led to improvements in drugs availability at Health Centers, and improvements in coordination between the Health Centers and the NMS through the Health Sector Anti-Corruption Working group. Multiplier benefits of project implementation included improvements in health service delivery through enhanced responsiveness of Health Centre workers.

Project implementation faced challenges relating to systemic challenges in the drugs supply mechanism. This was mainly related to the fact that Health Centers are not involved in drugs procurement and as a result, they usually received insufficient amounts of anti-malaria drugs in comparison with their disease burden and catchment population. Other challenges related to constraints in the health service delivery system including lack of skilled health workers to diagnose and treat malaria. At times drugs were not delivered according to schedules advertised by NMS, which affected the monitoring schedule. Lack of malaria diagnostic systems also contributed to constructive leakages as patients were dispensed with malaria drugs without ascertaining their malaria status.

The project has provided key lessons including the need to mainstream PAFs, working with communities to monitor drugs leakages. As a way forward, it was recommended that the project scope and period be widened and consider the context for health service delivery and malaria prevalence; ensuring that IBMs have sufficient knowledge to monitor drugs; the need to work with key stakeholder in monitoring drugs; and community sensitization.

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## **Acronyms**

ACCU	-	Anti-Corruption Coalition Uganda
ACW	-	Anti Corruption Week
CSO	-	Civil Society Organization
DHO	-	District Health Officer
FGD	-	Focused Group Discussion
HC	-	Health Centre
HSACWG	-	Health Sector Anti-Corruption Working Group
HUMC	-	Health Unit Management Committees
IBM	-	Independent Budget Monitors
NMS	-	National Medical Stores
NUACC	-	Northern Uganda Anti-Corruption Coalition
PTF	-	Partnership for Transparency Fund

## 1.0 Introduction

Anti Corruption Coalition Uganda (ACCU) was formed in 1999 and is the leading umbrella Civil Society Organization (CSO) which brings together civil society organizations to enhance strategies for fighting corruption in Uganda. ACCU envisions a just and free society and seeks to contribute to poverty reduction in Uganda by empowering civil society to actively and sustainably demand for transparent and accountable use of public resources.

With support from the Partnership for Transparency Fund (PTF), ACCU implemented a 12 months project titled, “*Preventing Leakages of Anti Malaria Medicines in Uganda’s Health Sector. A case of selected health centers in Lira District*”. The project was based on the premise that with 31 percent of Ugandans living in absolute poverty, many of them live in rural areas and depend on the public health system. Poor people cannot afford the high cost of private medical services and are therefore compelled to depend on government services.

However, poor people face challenges in accessing free medical services with the medicines delivery system being fraught with high leakages of drugs. In addition, the drugs delivery system for the lower Health Centers remains a challenge with health centers not receiving enough medicines they require for their populations. Patients are consequently asked to purchase their own drugs and those who cannot afford to buy drugs fall on the wayside which keeps them in abject poverty or even death. Malaria is a leading cause not only of ill health and death in Uganda and therefore, anti malarial medicines constitute a large percentage of medical consignments from national medical stores to public health centers

ACCU organized Anti corruption Week (ACW) 2007 focusing on leakages of essential medicines. The ACW 2007 was aimed at “Improving the management and availability of essential medicines”. This resulted in a renewed awareness among policy makers and the public on the types and extent of corruption in the health sector. After the campaign, the Ministry of Health to branded drugs meant for public health centers. Increased awareness of 2007 ACW led to arrests of health workers implicated in medicine pilferage, not only in the districts visited during ACW but also in other parts of the country, especially after labeling of the medicine destined for public health centers. However, despite the achievements of the initiative

spearheaded by ACCU, little has been done to avert the predicament. Cases of drug thefts are still come up in the media as well as reports of CSOs involved in the fight against corruption.

The PTF project was aimed at reducing the leakage of free malaria medicines by monitoring of the supply chain right from the National Medical Stores to the public health centers. The immediate outcome of the project was to improve public access to free malarial medicines destined for the target Health Centers in Lira district. Target health centers included the Regional Referral Hospital and 7 health centers of the lower levels (HC II – HC IV), selected from the four electoral constituencies of Lira district as follows:

	<b>Constituency</b>	<b># RRH</b>	<b># HC IV</b>	<b># HC III</b>	<b>Total</b>	<b># Target HCs for the project</b>
1.	Erute North	0	1	2	3	1 HC IV and 1 HC II
2.	Erute south	0	1	3	4	1 HC III and 1 HC II
3.	Lira Sub county	0	1	3	4	1 HC IV and I HC III
4.	Lira Municipality	1	4	4	9	1 RRH and III
	<b>Total</b>	<b>1</b>	<b>7</b>	<b>12</b>	<b>20</b>	<b>1 RRH, 2 HC IV, 3 HC III, 2 HC II</b>

*Notes: # HC means Number of Health Centre level ...*

*RRH means Regional Referral Hospital*

The health centers which participated in the pilot project were:

1. Ober HC III
2. Lira Municipal HC III
3. Bar Apwoo HC III
4. Ogur HC IV

5. Barr HC III
6. Abunga HC II
7. Lira Regional Referral Hospital
8. Ayago HC III

The project was implemented collaboratively with beneficiary communities, IBMs of NUACC and other health sector stakeholders (local leaders, technocrats and political leaders) in monitoring service provision at the health centers with particular emphasis on availability of malarial medicines.

## **2.0 Project Activities**

Activities implemented by the project were:

### **a) Baseline Survey**

This included tracking the status of the delivery chain of medicine from National Medical Stores to selected public health centers in Lira district. The baseline survey identified facts about loopholes or inadequacies in the flow of medicine to health centers in Lira district that guided ACCU in designing interventions aimed at reducing leakages.

### **b) Training Independent Budget Monitors**

Eighteen (18) selected Independent Monitors attached to NUACC were trained in monitoring of medicines in public health centers for improved accountability and transparency. The training equipped them with knowledge and skills to enable them to monitor drugs supply and availability at the health centers. Community monitors who were trained in monitoring medicines were expected to be at the frontline of the project and take charge of monitoring medicines availability at the health centers. Using monitors from the relevant communities was aimed at enhancing ownership of the project and ensuring sustainability. The monitors were facilitated with bicycles; and four cameras were purchased to enable them to document their findings.

### **c) Public Accountability Forums (PAFs)**

PAFs are anti-corruption dialogues held periodically between the health facility personnel, local government officials, beneficiary community members, anticorruption agencies and civil society. The PAFs were held at Ogur HCIV, Bar HCIII, Barapawo HCIII and Ober HCIII. The PAFs were expected to facilitate constructive interaction between health service beneficiaries and duty bearers on key issues concerning health service delivery, to identify key issues affecting health service delivery, and areas for action for improved services; and improved social accountability.

### **d) Health Sector Anti Corruption Working Group (HSACWG)**

A Health Sector Anti Corruption Working Group was established at national level, and the group met periodically-quarterly and addressed issues identified during drugs monitoring and provided

strategic guidance relating to provision of malaria drugs. They further suggested local solutions and generated opinions on developmental issues pertaining to the service delivery, and in this case the provision of free malaria drugs. Members of the working group were selected according to the key roles they play in the supply of drugs, and ensuring drugs availability to communities. They included:

- ACCU
  - Uganda Law Society
  - Ministry of Health
  - National Medical Stores
  - HEPS – Uganda
  - Directorate of Ethics and Integrity (DEI)
  - Medicines and Health Service Delivery Monitoring Unit
  - National Drug Authority
  - Northern Uganda Anti-Corruption Coalition
  - Directorate of Public Prosecutions
  - Malaria Consortium
- e) A newspaper supplement was also run in a local daily (Rupiny) to increase community awareness of the project and people's roles in reducing leakages.
- f) ACCU also undertook periodic monitoring with selected representatives of members the HSACWG
- g) The project also developed Information, Education and Communication materials to sensitize communities about the project and the drugs leakages.

### **3.0 Project Evaluation**

The evaluation exercise was aimed at assessing the effectiveness of the pilot project and to draw lessons for the proposed replication; and it addressed the following key questions:

- To what extent have the strategies and activities supported by PTF achieved their goals and objectives?
- What has been the impact of project activities? Have there been any unforeseen impacts?
- What challenges were confronted by the project and how were these addressed?
- What lessons have been learnt from the project?
- What recommendations can be made on the future direction of PTF support?

### **3.1 Evaluation Methodology**

The evaluation was undertaken as a participatory process which facilitated input from all relevant stakeholders, including national and local participants. In undertaking the evaluation, the consultant undertook the following tasks.

#### **3.1.1 Document Review**

The consultant reviewed relevant information relating to the project concept, baseline survey report, project implementation reports, minutes, Health Centre reports on malaria incidence and drugs delivery. The document review provided the context and background for the evaluation.

#### **3.1.2 Key Informant Interviews**

The consultant also held key informant in-depth interviews with key stakeholders in the project including the ACCU and NUACC project coordinator, health centre officials, the district director of health services and members of the Health Sector working group. The key informant interviews facilitated data collection of project implementation and its impact as well as generate information on the changes in drugs availability brought about by the project, challenges, lessons and recommendations for project replication.

### **3.1.3 Field Visits**

The consultant undertook a field visit to four target health centers in Lira district. These were Lira Regional Referral Hospital, Ogur HC IV (which serves about 5 districts), Barr HC III and Ayago HCII. The field visits facilitated an interaction with health workers, IBMs and Local Government personnel working with the project; and an assessment of assessment of key factors affecting availability of drugs and issues relating to leakages within Lira district.

During the field visits, the consultant also held Focus Group Discussions (FGD) with NUACC IBMs to generate information on the work of the IBMs and NUACC; documentation of their experiences in monitoring the drugs delivery system and availability, challenges, successes, best practices and recommendations for replication of the project. FGDs also availed information on key project implementation activities and their impact on drug availability.

## **3.2 Findings of the Evaluation**

The findings of the evaluation are categorized according to the key evaluation questions:

### **3.2.1 Extent to which the Strategies and Activities Supported by PTF Achieved their Goals and Objectives**

The project purpose was to reduce the leakage of free malaria medicines through monitoring the supply chain from the National Medical Stores to selected health centers in Lira district, and thereby improve public access to free malarial medicines destined for the target health centers.

#### **3.2.1.1 Training Monitors and Monitoring of Drugs Supply and Delivery**

The trained IBMs acquired knowledge and skills which enabled them to effectively monitor drugs supply from the district to the Health Centers. The ACCU project coordinator was directly in touch with NMS and before a consignment was sent, ACCU would get a list of medicines to be delivered to the Health Centers. ACCU would identify the anti-malarial drugs destined for the target Health Centers and avail it to the IBMs to enable them track the delivery of medicines to the district. This information was correlated by the monitors when they went to monitor, to establish whether the actual medicines have reached the Health Centers. In addition, as a result of the productive working relationship established between NUACC and the district, the district officials always called on the IBMs to inform them of the arrival of the medicines to the districts, thus enabling the monitors to be present when drugs were delivered to the district. ACCU also

received a delivery schedule which has timetables for ordering and delivery of drugs to the districts.

In ascertaining whether drugs from NMS had reached the Health Centers, the monitors undertook routine monitoring visits to the Health Centers. In doing this, the monitors would request for information on drugs delivery from the in-charges of the Health Centers. Monitors would scrutinize the delivery notes, the number of malaria cases and the drugs that have been dispensed to the patients and those still remaining. Whenever drugs were delivered to the Health Centers, the HUMCs and IBMs were able to verify the deliveries. In case drugs were missing, the district would be informed, which would in turn, inform NMS. In some cases the missing drugs would be supplied by NMS, but in other cases they would not be supplied.

IBMs were also availed with cameras which they used to document the activities they are doing; following other cases or where patients are complaining of ill-treatment by health officials so they would try and sort out the problem. Monitors would meet with Health Centre staff and HUMCs to advise them on procedures for receiving drugs, and seek their assistance to help them to monitor the drugs. Co-opting the HUMC members was an initiative of the IBMs because they realized that since HUMCs oversee the operations of the Health Centers and come from the areas where the Health Centre is located, they would be an extra force in monitoring drugs dispensation at the Health Centers. Furthermore, it soon became known that the IBMs were monitoring anti-malaria drugs, and they realized that Health Centre staff may begin to dodge them. Therefore co-opting HUMC members was a strategy to ensure that someone was monitoring the Health Centre all the time.

In addition to talking to the HUMCs and Health Centre staff about drugs monitoring, the IBMs would discuss other issues relating to service delivery at the Health Centers. These included patient care, the issue of staff late coming and early arrivals, and absenteeism. The IBMs would also share their findings about the issues that they would identify at the particular Health Centers and work with HUMCs and health centre staff on addressing these issues.

During monitoring, the IBMs would also talk to the patients to find out their experiences in accessing services at the particular Health Centers, like patient care, availability of Health Centre staff, access to medicines. They would then compare this with the information they received from Health Centre staff to get a true picture of the situation. After that, the IBMs would meet with the District Director of Health Services (DDHO) to share the findings of monitoring from different Health Centers. The DDHO reported that the NUACC IBMs have helped the DHO in reducing drugs leakages. She noted that much as the DHO's office is supposed to undertake support supervision, they are unable to do it perfectly because the DHO undertakes an integrated supervision and may not be able to dwell on a particular issue but IBMs are able to track the drugs from the districts to the Health Centers and the communities, and they are able to interact with the communities surrounding the Health Centers where they get both sides of the story. The IBMs could reach the Health Centers and had assisted in monitoring and reducing drugs leakages by health workers and the community members. Furthermore, through the HSACWG, ACCU and NUACC assisted the DHO to track and solve medicines' delivery issues with NMS.

### **3.2.1.2 Radio Programs**

Under the project, four radio talk shows and a 60 day radio jingle were undertaken to sensitize people on the project, and how best they could play roles in preventing drugs leakages. During the radio programs, the IBMs would share the findings from monitoring of drugs supply at the Health Centers, and issues that came up during monitoring. The IBMs also used the radio talk shows to mobilize communities to provide IBMs with information on drugs leakages. The IBMs realized the need to work with communities to prevent drugs leakages, and to change the attitudes of community members who steal drugs. Public support would also facilitate provision of information, making it easier for IBMs to intervene in cases of drugs leakages.

Radio programs enabled the IBMs to raise awareness of the project and the role of IBMs. During the talk shows, many people would call from different places, even beyond Lira, like Amolatar, Oyam, Otuke, Apac, and Kole seeking the assistance of the IBMs in reducing drugs leakages in their areas. The callers knew about the project from the radio programs and they picked interest in the project.

### **3.2.1.3 Public Accountability Forums (PAFs)**

These were anti-corruption dialogues held between the Health Centre staff, local government officials, beneficiary community members, anticorruption agencies and civil society. The PAFs facilitated dialogue between health facility users and duty bearers and identify ways of improving health service delivery. The objective of the PAFs was to engage communities at district and sub-county levels, together with the health personnel and give them an opportunity to talk about their experiences regarding the particular Health Centers.

PAFs were held quarterly, and were organized after monitoring at the Health Centers. Community members, the DHO's office, local leaders attended the PAFs. The attendance of the DHO and local leaders was aimed at ensuring that issues that require their attention are brought up for redress. During the PAFs, the IBMs would share findings from the monitoring and invite the responsible people to respond to issues arising. The presence of local leaders and the DHO further assisted the Health Centre staff because sometimes the staff would have issues that they wanted to share with the DHO to try to solve the problems.

The IBMs also used the PAFs to appeal to communities to help them monitor drugs. They sensitized communities about government drugs, and how communities can identify government drugs being sold in the private clinics by looking out for the Uganda government embossment on the drugs. Communities were urged to alert their leaders or the IBMs whenever they find government drugs on sale in private clinics. As a result, community members have become very vigilant in looking out for government drugs being sold in private clinics. It is now harder for people to steal drugs and sell to nearby community members who are now enlightened.

### **3.2.1.4 Health Sector Anti-Corruption Working Group (HSACWG)**

The HSACWG was formed at national level, and it brought together different stakeholders with a view of influencing policy and effect change. Where issues regarding drugs supply or leakage came up, the relevant government agency would be represented to clarify issues or take up the matter. The HSACWG was established with the view that some issues would arise at implementation level that could require national level interventions through partners in the

Ministry of Health or NMS to move forward. ACCU mapped the different stakeholders in the health sector who would be instrumental in achieving the project objectives. The group met quarterly to receive reports of project implementation and address issues arising from monitoring drugs supply and delivery at the Health Centers, and would provide guidance on issues arising from monitoring.

Members of the HSACWG found the group productive in that working together enabled them to identify bottlenecks in drugs supply and health service delivery. Members of the group were part of the quarterly monitoring visits to the Health Centres where they were able to identify gaps, some of which were addressed even without resources. These included issues of health workers' conduct, patient care and sanitation. This enables the health workers to provide the minimum care to patients

The HSACWG was a good innovation because it enabled ACCU to get a buy-in from key stakeholders in the different agencies that are mandated to ensure transparency and accountability in supply and monitoring drugs. Moreover, working together as a group facilitated sharing of information and identifying solutions to improve drugs supply and reduce leakages; and to appreciate each others' roles and contributions.

In addition, having key stakeholders in this alliance made it easier for ACCU to access these offices when issues relating to drugs supply and leakages came up. Having focal people within the working group helped a lot in following up cases. In addition the guidance and technical experience of the HSACWG in the area of delivery of medicines was invaluable. They provided information and guidance on many policy issues relating to delivery of medicines. At local levels IBMs worked with individual offices to solve issues that arose. In addition, the district health office played a key role in ensuring that the project was successful.

The strategies and activities adopted to implement the project were, to a large extent, able to contribute to achieving the project goals and objectives.

## **3.2.2 Impact of Project Activities and Unforeseen Impacts**

The project was implemented for 12 months, and the most significant impacts were:

### **3.2.2.1 Improvements in Drugs Availability**

IBMs and Health Centre in-charged noted that at the beginning of the project the lower Health Centers (IIs and IIIs) would experience drug stock-outs within a week of delivering the drugs. However, due to the project, some Health Centers report that their stock of anti-malaria drugs lasts between two weeks to a month, depending on the catchment population of the Health Centre.

IBMs noted that at times drugs are delivered and some HCs do not receive anti-malaria drugs. At one point Barr Health Centre did not receive anti-malaria drugs, and the district informed NUACC which in turn communicated to ACCU. ACCU followed up the case and in the subsequent delivery, Barr Health Centre received double the amount of anti-malaria drugs to compensate for the period they did not receive, which had not happened. Once a Health Centre missed out on anti-malaria drugs, they would not be compensated. They would have to wait for the following consignment.

### **3.2.2.2 Community Empowerment**

Through the radio programs and the PAFs, community members have become empowered about their rights to access medicines and quality service delivery. IBMs empowered the community to monitor leakage of government drugs, and the communities presently monitor drugs supply and dispensation. The Lira Hospital Director who undertakes support supervision for lower Health Centers also noted that the project has been vital in enhancing community empowerment to demand for drugs and better service delivery. He noted that whenever community members do not find drugs at the Health Centres, they put the Health Centre staff to task to explain the lack of drugs.

### **3.2.2.3 Improvements in Health Service Delivery**

Through the PAFs, IBMs created a forum for community members to express their opinions on the quality of service delivery. prior to the project, community members were passive recipients

of health services, but when IBMs informed them of their rights to quality services, communities are now empowered and can now talk boldly about service delivery at the Health Centre and the behavior of health workers. The Director of Lira regional referral hospital undertakes support supervision of the lower Health Centers and noted that communities are now empowered, and demand for explanations whenever they find no drugs at the Health Centers.

In addition to monitoring drugs leakage, IBMs also look at the general performance of the Health Centers. Whenever there are issues relating to service delivery, monitors have also talked to health workers about patient care. The IBMs have witnessed improvements in the behavior of health workers who used to come late and leave early. During the project period, health workers are at work during the times that they are supposed to be at work. The health workers have changed their behavior because they know that people are watching them. Monitoring at Health Centers has contributed to reducing absenteeism of health workers.

Monitoring by the IBMs and their interaction with community members has also helped to bridge the gap between the health workers and the community. IBMs are able to explain to communities about drug stock-outs, thus reducing community suspicion that whenever drugs are unavailable, they have been stolen by health workers.

#### **3.2.2.4 Recognition of the Role of the IBMs in Reducing Drugs Leakages**

IBMs have become known as the front runners against drugs leakages, and communities and Health Centers officials are now reporting cases to the IBMs. Furthermore, the IBMs have established a collaborative working arrangement with duty bearers to reduce drugs leakages and ensure that communities receive high quality drugs. For instance, when a case of theft of anti-malaria drugs was discovered at Ogur HCIV (one of the target Health Centers), the in-charge quickly informed the IBMs who were able to follow up the case which involved prosecution, conviction and sentencing of the offender.

Furthermore, whereas IBMs are monitoring only Coartem, they are now receiving complaints regarding availability and/or quality of other medicines. When NMS supplied sub-standard

Albendazole to Lira regional referral and it was later recalled, the IBMs informed the DHO and other HCs who returned it to the district awaiting its pick-up by NMS.

### **3.2.2.5 Improvements in Access to Information**

At the time of the baseline survey, IBMs noted that it was very hard to get information from Health Centers, but they now easily access information from the Health Centers. IBMs advocated for the rights to access the information.

All in all, the project has contributed to bringing about responsibility and accountability on the part of duty-bearers to ensure that the little that is brought to the community actually reaches them. However, the project had a short lifespan of 12 months and with drugs being delivered every two months, IBMs were supposed to monitor six consignments, but there were delays in some deliveries which affected their monitoring schedule.

## **3.2.3 Challenges Confronted by the Project and how they were addressed**

### **3.2.3.1 Shortcomings of the Drugs Supply and Delivery Mechanism**

Save for the Regional Referral hospital, the district hospital and the Health Centre IVs which order for their own drugs, the Health Centre IIs and IIIs receive drugs through a push system where NMS supplies drugs to them irrespective of their disease burden or catchment population.

The evaluation found that anti-malaria drugs are not supplied in sufficient quantities. In addition, even when coartem is supplied, the types of coartem that cater for different age groups are never supplied at the same time. There are four types of coartem to cater for the different age groups - yellow, green, blue and brown. However, IBMs reported that when they are monitoring, they have never found all the four types available or delivered at the same time. This creates problems for health workers, because trained health workers know which drugs to give people to heal them; but they end up giving them less doses. When health workers inform patients that coartem for their age group is not available, communities complain that health workers are giving other patients coartem, but not them, which also creates problems for the health workers. In other cases, Health Centers are usually supplied with drugs that they do not require.

The limited amounts of anti-malaria drugs available at lower Health Centers has created undesirable consequences in that when people know that drugs have been delivered to Health Centers, they have resorted to feigning malaria symptoms so that they can stock anti-malaria drugs, thus worsening the stock-out situation.

ACCU brought the issue of limited amounts of anti-malaria drugs to the attention of the HSAWG and was informed by NMS that the issue would be considered during the annual health sector policy reviews. ACCU and other stakeholders are advocating for a combination of the push and pull system whereby Health Centers are given an opportunity to participate in requesting for drugs to ensure that they receive what they require considering their disease burden and the catchment population. Alternatively, it has been suggested that HCs should make their orders for drugs and deliver them to the DHO who can compile drugs requests and make orders for the whole district.

As has been noted above, NMS provides drugs delivery schedules to indicate when drugs would be delivered to the district. However, the drugs delivery schedule was not always followed. During the project period, drugs were not delivered in one instance, which affected the monitoring schedule for the IBMs. According to key informant interviews, this usually happens, despite advertisements from NMS that drugs have been delivered. Considering the fact that lower Health Centers do not have direct contact with NMS to request for drugs, this affects drugs availability at these Health Centers.

The situation is different at Lira Regional Referral Hospital which has its own budget for drugs supplies. The referral hospital is in direct contact with NMS regarding drugs delivery and ensures that when drugs are delivered, they compare the delivery vouchers to the actual drugs delivered. However, at times they find that the order does not agree with the delivery; or NMS under-supplies, or supplies items that they did not request for. In addition, the regional referral hospital has noted that at times the quality of drugs or medical supplies is not up to standard. The referral hospital noted instances of poor quality drugs and supplied being delivered, and being recalled after an outcry from the Health Centers. Unfortunately, by the time drugs are recalled, some patients would already have consumed them.

Furthermore, NMS contracted a last-mile supplier to deliver drugs from the district to the Health Centers. It was found that in many cases the Health Centers do not have information as to the exact time that the last mile supplier will deliver drugs to Health Centers, which affects the capacity of the Health Centre staff to mobilize HUMCs and IBMs to verify the drugs. Moreover, sometimes drugs are delivered as late as 5.00pm or on weekends, meaning that verification goes on at night. This would make the last mile supplier rush the HUMCs through the verification process – thus they may end up counting the boxes rather than examining the contents of the boxes or packages.

### **3.2.3.2 Constructive Leakages**

The evaluation found that in many lower Health Centers, leakages of drugs take place on the instigation of community members. As has been noted above, NMS usually delivers insufficient amounts of anti-malaria drugs. To ensure that they have drugs when they need them, community members have mastered the symptoms of malaria and then go to the Health Centers with malaria symptoms in order to get drugs that they can stock for the future.

This scenario is compounded by the fact that whereas NMS is supposed to provide Rapid Diagnostic Testing (RDT) kits for malaria, many of the lower Health Centers do not have regular supplies of the RDTs; and Health Centers like Ogur HCIV which serves a big catchment population does not have a laboratory technician to test patients for malaria. As a result, Health Centre staff diagnose malaria basing on clinical assessments, and thereafter dispense drugs to patients without ascertaining whether or not they have malaria. Interview respondents stated that when community members learn that drugs have been delivered, they go to the Health Centre seeking for anti-malaria drugs; and this contributes to reducing the availability of drugs at the Health Centre. The DHO noted that this is a type of leakage through wastage of drugs, at the expense of people who may be genuinely sick, but will arrive at the Health Centre and find a malaria drug stock-out. The DHO further noted that with the absence of functional laboratories and malaria testing kits, it becomes difficult to ascertain how drugs get out of the Health Centers; and that if a Health Centre staff is not trustworthy, then s/he may clerk ghost patients as having received medicines. In addition, there is need for massive citizen education to enhance community responsibility for reducing leakages

### **3.2.2.3 Health Service Delivery Challenges**

Key informant interviews noted that issues regarding health service delivery are complex and multi-faceted, with one aspect having an impact on other areas of service delivery. It came out during the field visits that many of the lower Health Centres did not have qualified staff to attend to patients. In the absence of fully functional laboratories and qualified staff, unqualified staff end up diagnosing and dispensing medicines depending on clinical assessments, which, according to the Director of Lira Regional Referral Hospital, leads to wastage of drugs. However, HSACWG noted that the Ministry of Health faces limitations in recruiting qualified staff because the government of Uganda placed a ban on recruiting civil servants, which ban has remained in place for a long time. In addition, the HSAWG members noted that there is need for government policy to address retention of health workers, especially in the hard to reach areas of the country. Key informants further noted that many Health Centres have nursing aides who do not have the capacity and ability to know the drugs that are required by the Health Centres. Under the circumstances, NMS was compelled to introduce the push system in which NMS delivers what it assumes are the right quantities for the Health Centres.

### **3.2.2.4 Implementation Challenges**

Monitors noted that they were trained in monitoring medicines at the beginning of the project, but that there was a change in monitors during the project implementation period; and the new monitors needed indepth training too. Furthermore, the pilot project was implemented in selected Health Centers, but they received numerous calls and demands to intervene in non-project areas which they were unable to do. In addition, the monitors were inundated with requests to monitor drugs that were not part of the project target medicines. The Health Centre staff argued that this may need attention because malaria treatment may require dispensation of other medicines; and they also need to be monitored to ensure that they are available when patients require them.

### **3.2.3 Lessons Learnt from the Project**

- a) Monitors learnt that community members are an important key stakeholder in monitoring drugs leakages; and that it is imperative to sensitize communities and get their buy-in in monitoring drugs leakages and ensuring access to medicines. Once the public joins the cause, then the leakages can be reduced.
- b) Public accountability forums should be a norm and culture in every Health Centre so that people can come out and talk about their grievances. Whereas the government of Uganda introduced barazas to enhance local government responsiveness and accountability, the barazas have become highly politicized and people are intimidated not to talk. PAFs as citizen-led forums would be an integral part in enhancing accountability of Health Centers.
- c) There is need to have functional Local Councils in the country. Local Councils were established to enable people deal with issues that take place within their localities; and they were meant to play a pivotal role in among others, monitoring service delivery. However, to date Local Councils are non-functional, yet they are supposed to be the first point of contact even before community members going to police.
- d) Need for refresher training: the project recruited and inducted monitors in monitoring anti-malaria drugs. The training done at the beginning of the project, yet some monitors left and the new ones were not trained, yet they were expected to hit the ground running yet they had no skills to monitor. Refresher trainings would enable all monitors to be on an equal footing.
- e) Working with the HSACWG brought out the fact that issues of health service delivery are complex; and effective tackling of leakages should look at the wider context where drugs theft may be symptomatic of bigger issues. HSACWG members noted the need to look at issues relating to staffing of the Health Centres and remuneration of health workers. To date the Ministry of Health is advocating for the advancement of health workers' pay to ensure recruitment and retention of qualified health worker who have the capacity to effectively diagnose and prescribe the right medicines.
- f) The project did not focus so much on the fact that anti-corruption work is a risky business. The monitors were threatened at the early stages of the project. When they tried to shoot a documentary, people at the regional referral hospital were not willing to talk to them.

### **3.2.4 Recommendations on the Future Direction of PTF Support**

- a) Expand the geographical scope of the project to cover more Health Centers. The project was piloted in 8 Health Centers but monitors received numerous requests to cover other Health Centers. Furthermore, the monitors noted that monitoring in the pilot Health Centers contributed to reducing leakages and increasing citizens' activism, which is not the case in other Health Centers, yet they did not have the capacity to go to other HCs. For the project to yield fruit, it should cover a wider area so that the whole district can be monitored.
- b) The project could widen its focus and look at other public health issues that affect the malaria incidence. Sensitizing communities on public health issues like sanitation and prevention of malaria from home, because many of these factors begin at home. Other areas for community sensitization include the value of using mosquito nets for their rightful purpose. Furthermore, malaria sometimes comes with complications that need to be treated with other drugs; so there is need to expand the scope from monitoring only anti-malaria drugs.
- c) Future projects should consider the wider context of health service delivery within which the drugs leakages occur. Key informants argued that reducing malaria should also look at the capacities of the Health Centers, because many Health Centers do not have skilled personnel to attend to patients. The human resource aspect needs to be considered, because the cases where drugs leakages were found, the instigators are support staff rather than skilled health workers. Furthermore, the project should consider a bigger role for policy advocacy to address issues relating to drugs supply and leakages advocate, for instance, functional laboratories at Health Centers to address dispensing of drugs without ascertaining malaria and ensuring that Health Centre staff do not clerk 'ghost' patients as having received drugs when the patients do not exist. This would contribute to reducing leakages. Other key informants noted that issues like NMS' drugs delivery schedule may appear like an operational matter, but from a policy perspective, there is need to consider having Health Centers generate drugs procurement plans to guide NMS in budgeting for the drugs.
- d) A future project should consider a more integrated collaboration with the National Medical Stores. During the project period, it was revealed that on several occasions NMS printed in the newspapers that they had delivered drugs yet they had not. For instance, at one point they claimed to have delivered TB drugs yet they had not done so for two months; and people

from the regional referral hospital had to pick the drugs from NMS. This was corroborated by target Health Center in-charges who stated that many times they lack drugs yet NMS had advertised that they had delivered drugs. Furthermore, NMS had not delivered fansidar (an anti-malaria drug) to Health Centers for the last three months of the project period.

- e) The pilot project was implemented for a period of 12 months, which was limited if one is to get more tangible results. Considering the challenges in delivery of medicines, IBMs' monitoring was hampered due to the challenges in delivery of medicines. The project was meant to monitor 6 delivery scheduled yet there were delays in delivering medicines during the project period, meaning they could not monitor all the delivery scheduled. A project of a longer period would have given ACCU and the IBMs more time to monitor and get more tangible results. However, as it is, the project area did not avail sufficient time to study and analyze the issues, and do a rigorous comparative analysis of the situation before and after project implementation.
- f) There is need for massive community sensitization to bring them on board to reduce the constructive leakages that are instigated by community members.
- g) HUMCs were established by government to oversee the operations of Health Centers. Part of their work includes verifying drugs deliveries, monitoring drugs leakages and service delivery. However, not all HUMC members have the capacity to verify drugs leakages, which includes interpreting delivery notes to ascertain that what is in the note is what has actually been delivered. There is need to build capacity of HUMCs to better track drugs at the Health Centers. Building the capacity of HUMCs would also create a team to work with the IBMs. IBMs noted that they can be easily spotted when they go to monitor, and the Health Centre staff can clean up their act during monitoring. However, if different stakeholders are involved, it becomes very difficult to know who is monitoring that at a particular time.
- h) A future project should work towards strengthening the partnership of stakeholders involved in health service delivery and clarify on ground rules for stakeholder partnerships.

## **4.0 Conclusion**

The PTF project was aimed at reducing the leakage of malaria medicines by monitoring of the supply of medicines from the National Medical Stores to the target health centers, and several activities were implemented to achieve this objective. The evaluation found that 12 months after the project began, it has registered considerable successes in achieving its objective. The evaluation found that anti-malaria drugs availability, though still insufficient due to systemic factors, had improved during the project period.

Furthermore, the project had greatly contributed to empowering communities to monitor drugs' leakages both in and outside government Health Centres. Project activities had also contributed to reducing the gap between health workers and communities, with the biggest multiplier benefit being the improvement in service delivery within the target Health Centres.

Nevertheless, the project faced challenges mainly related to the drugs supply and delivery systems; and health service delivery challenges which create opportunities for communities to participate in drugs leakages. Addressing these challenges needs to be mainstreamed in future projects of a similar nature.

The project provided key lessons including the need to mainstream PAFs, working with communities to monitor drugs leakages. As a way forward, it was recommended that the project scope and period be widened and consider the context for health service delivery and malaria prevalence; ensuring that IBMs have sufficient knowledge to monitor drugs; the need to work with key stakeholder in monitoring drugs; and community sensitization.

## **Annexes**

### **a) Interview guides**

#### **ACCU Project coordinator**

1. What were the objectives of the project?
2. What activities did you implement to achieve the objectives?
3. In your assessment, how successful have you been in achieving your objectives?
4. What challenges did you experience in implementing the project?
5. Are there any assumptions or risks relating to the objectives that you would re-visit?  
Why?
6. How effective has the HSACWG coalition been - jointly and individually? How have u worked with each of them?
  - a. Where have the synergies been effectively utilized?
7. How was the monitoring of supply of drugs from the health to the district undertaken; and by whom?
  - a. What were the successes and challenges in drugs monitoring?
  - b. How effective is the drugs monitoring – capacity to monitor (financial, time, etc – resources)
  - c. What lessons have you learnt from implementing the project?
  - d. What recommendations would you have for future replication of a similar project?
8. How does the push system for anti-malaria drugs affect the actual access to drugs by the end users?
9. What changes in availability of medicines and health service provision do you attribute to implementation of the project?

10. What other factors would you take into consideration in future projects of a similar nature – considering the preventive and treatment aspects of malaria, including health service delivery and malaria diagnostic capacity of the health centers?
11. What was the role of NUACC and the IBMs in the project implementation?
12. What roles have HUMCs undertaken in the project?
13. Who verifies drugs on delivery?
  - a. What role do HUMCs play during drugs delivery?
  - b. Do health centers and HUMCs get timely information on drugs delivery – times and batches?
  - c. What capacity do the IBMs have to detect drugs' leakages; and how easy has it been for the IBMs to detect drugs leakages?
14. Were there any reported cases of drug leakages? How were they resolved?
15. How has the project contributed to increasing public access to malaria drugs?
16. How do health centres track drug stocks?
17. Do patients receive the prescribed medicines at the HCs free of charge?
18. Are there any other positive or negative results that have taken place as a result of implementing the project?
19. What lessons have you learnt from implementing the project?
20. Recommendations for future similar projects?

**b) NUACC coordinator**

1. What role did NUACC and the IBMs play in project implementation?
2. What activities did you implement to achieve the objectives?
3. In your opinion, how successful have you been in achieving your objectives?
4. What challenges did you experience in implementing the project?
5. Which partners did you work with at local levels?

**Drugs supply mechanism**

6. How did you monitor drugs from the Ministry of Health to the Health Centres?
  - a. What were the successes and challenges in drugs monitoring?
  - b. How effectively were IBMs able to monitor drugs supply?
  - c. What lessons have you learnt from monitoring drugs leakages?
  - d. What recommendations would you have for future replication of a similar project?
7. How does the push system for supplying drugs affect the actual access to drugs by the end users?
8. Are there any changes in availability of medicines and health service provision that you attribute to implementation of the project?
9. What do you see as the biggest change that the project has brought to drugs availability in the target Health Centres?

**Drugs leakages**

10. How are drugs verified on delivery? What was the role of the coordinator?
  - a. What role did HUMCs play during drugs delivery? How did they participate in verifying drugs delivery in the project areas?

- b. Do health centers and HUMCs get timely information on drugs delivery – times and batches?
  - c. What capacity do the IBMs have to detect drugs’ leakages; and how easy has it been for the IBMs to detect drugs leakages?
11. Were there any reported cases of drug leakages? How were they resolved?
  12. How often do the health centre experience stock-outs?
  13. How did the project contributed to increasing public access to malaria drugs?
  14. How do Health Centres track drug stocks?
  15. Do patients receive the prescribed medicines at the HCs free of charge?
  16. Are there any other changes, for instance in service delivery, that can be attributed to the project? Elaborate.
  17. What lessons have you learnt from implementing the project?
  18. What recommendations would you have for future similar projects?

**c) In-charges**

1. How did you work with NUACC and the IBMs in implementing the project?

**Drugs supply mechanism**

2. How are drugs supplied to the Health centre? – process
3. What is the role of the in-charge in monitoring the supply of drugs from the health ministry to the district? Do you receive timely information on drugs supply?
4. How does the push system affect the actual access to drugs by the end users?
5. How does the Health Centres monitor drug stocks within the health facility?
6. How has the project contributed to availability of drugs and health service provision at the Health Centre?
7. What do you see as the biggest change that the project has brought to drugs availability in your health facility?
8. Who verifies drugs on delivery?
  - a. What role do HUMCs play during drugs delivery?

- b. Do health centers and HUMCs get timely information on drugs delivery – times and batches?
- 9. What capacity do Health Centres have to detect drugs leakages?
- 10. How do drugs leakages occur at health centers, and how can this be addressed?
- 11. Were there any reported cases of drug leakages? How were they resolved?
- 12. How does the Health Centre diagnose malaria cases?
- 13. How often do the health centre experience stock-outs?
- 14. How has the project contributed to increasing public access to malaria drugs?
- 15. Do patients receive the prescribed medicines at the HCs free of charge?
- 16. Are there any other positive or negative results that have taken place as a result of implementing the project?
- 17. Are there any other changes, for instance in service delivery, that can be attributed to the project?
- 18. What other factors should be taken into consideration in future projects of a similar nature?
- 19. What lessons have you learnt from the project?
- 20. Recommendations for future similar projects?

**d) District Director of Health**

- 1. In your assessment, how effectively has the project contributed to reducing drugs leakages in the district?
- 2. What do you see as the challenges in reducing drugs leakages in the district?
- 3. How is the monitoring of supply of drugs from the district to Health Centres undertaken? How effective was the monitoring chain in monitoring and providing information to the next person in the chain?
  - a. Challenges and successes in this chain of monitoring?
- 4. How does the fact that anti-malaria drugs are supplied as part of the push system affect the actual access to drugs by the end users?

5. What changes in availability of medicines and health service provision would you attribute to implementation of the project?
6. What do you see as the biggest change that the project has brought to drugs supply in Lira district?
7. Are there any other changes, for instance in service delivery, that can be attributed to the project?
8. How effectively can HUMCs participate in preventing drugs leakages?
9. How do Health Centres track drug stocks?
10. How effective is the Health Centre system for detecting drugs leakages within the HC?
11. Have you received any cases of drug leakages? How were they resolved?
12. How effective is the system for treating malaria in the health centre/district?
13. How does the fact that HCs have little/no diagnostic systems for malaria affect the proper use to which malaria drugs are put?
14. How has the project contributed to increasing public access to malaria drugs?
15. What other factors affect health service provision that need to be considered in future projects of a similar nature?
16. Are there any other positive or negative results that have taken place as a result of implementing the project?
17. What other factors would you take into consideration in future projects of a similar nature?

**e) Independent Budget Monitors**

1. What activities did you implement in the project?
2. What challenges did you experience in implementing the project?
3. What was your role in monitoring of supply of drugs from the district to Health Centres?
4. Did you receive timely information on drugs supply to facilitate monitoring?
5. What successes and challenges did you register in drugs monitoring?
6. Are there any changes in availability of medicines and health service provision that you attribute to implementation of the project?

7. What do you see as the biggest change that the project has brought to drugs supply in the target Health Centres?
8. What role did you play in verifying drugs on delivery?
  - a. Did you receive timely information on drugs delivery – times and batches?
  - b. What capacity do the IBMs have to detect drugs' leakages; and how easy has it been for the IBMs to detect drugs leakages?
9. Are there any changes in drugs leakages as a result of the project?
10. Were there any reported cases of drug leakages? How were they resolved?
11. How often do the health centre experience stock-outs?
12. How do HCs diagnose malaria? What criteria do Health workers use to prescribe malaria drugs?
13. Has the project contributed to increasing public access to malaria drugs?
14. How do health centres track drug stocks?
15. Do patients receive the prescribed medicines at the HCs free of charge?
16. Are there any other positive or negative results that have taken place as a result of implementing the project?
17. What lessons have you learnt from implementing the project?
18. What recommendations would you have for similar future projects?

f) **Key Informant interview – Health Sector Anti-Corruption Working Group**

1. Briefly explain the work of your agency and its role under the TPF project.
2. Were there any reported cases of drug leakages during the project implementation period that were brought to your attention? What role did your agency play in such cases?
3. What was the contribution of the working group to the PTF project?
  - a. What synergies have you found useful in the coalition?
4. Are there any policy issues relating to the project that came to the attention of the working group? How successful was the working group in addressing such issues?

5. What would you consider as the biggest value addition that the working group had on the project?
6. What challenges has the working group faced in addressing issues regarding drugs leakages/ availability under the project?
7. Looking ahead, what recommendations would you have for improving the effectiveness of the working group?
8. What changes in availability of medicines and health service provision do you attribute to implementation of the project? NMS

**g) List of people interviewed**

- Abbas Kigozi, Coordinator, PTF Project, ACCU
- Felix Opwonya, IBM coordinator, NUACC
- Okot Gino, senior clinical officer, Bar HCII.
- Wesley Mesach Ochieng – Senior Clinical officer/anesthetic officer, Ogur HCIV
- DHO, Lira District
- Ochen William – Director, Lira Regional Referral Hospital
- Lwigale Henry, Lira Regional Referral Hospital Administrator
- Okello Ramathan Swabir, NUACC IBM
- Amongi Susan, NUACC IBM
- Ojok Justine, NUACC IBM
- Health Sector Anti-Corruption Working Group members